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| **County of Sacramento<br>Department of Health Services<br>Division of Behavioral Health Services<br>Policy and Procedure** | Policy Issuer (Unit/Program) | Mental Health Services |
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| Title:<br><br>**Child and Family Team** | Functional Area:<br><br>**Programs** |

Approved By: *Signed version available upon request*

Melissa Jacobs, LCSW
Division Manager, Division of Behavioral Health Services

## Background/Context:

Assembly Bill (AB) 403, known as the Continuum of Care Reform (CCR), was implemented to reduce the rate of placements of children and youth in congregate care and group homes. The intention of the CCR is to have children and youth, who must live apart from their parents, be able to live in a permanent home with a committed adult(s) who can meet their needs.

Sacramento County Mental Health Plan (MHP) values the Integrated Core Practice Model (ICPM) and strives to integrate ICPM's core principles. ICPM is a set of practices and principles that provide practical guidance and direction to the delivery of timely, effective, and collaborative services to children/youth and their families. One core component of the ICPM is the establishment of a Child and Family Team (CFT) to guide the services provided to children/youth and their families. The CFT's role is to include the child/youth and family members in defining and reaching identified goals for the child. The individuals on the team work together to identify each family member's strengths and needs, based on relevant life domains, to develop a child, youth, and family-centered treatment plan.

## Definitions:

**Avatar or Other Electronic Health Record (EHR):** A cloud-based, web-accessible EHR system that mental health providers and substance use prevention and treatment services providers use to document services, manage billing, and produce reports.

**Child and Family Team (CFT):** A group of individuals that includes the child or youth, family members, professionals, natural community supports, and other individuals identified by the child/youth/family who are invested in the child, youth, and family's success. In addition to mandated participation of involved public agency representatives, the composition of the team is driven by family members' preferences. The CFT engages in a variety of processes to identify a shared vision and the strengths and needs of the child/youth and his/her/their family, to help achieve positive outcomes for safety, permanency, and well-being.

**CFT Meeting:** A functional structure and process of engaging the family and the service teams in thoughtful and effective planning. The CFT typically conducts and coordinates its work through a CFT meeting. A CFT meeting does not represent the entire process, but is simply one part of a larger strategy, which involves children, youth, and families in all aspects of care planning, evaluation, monitoring and adapting, to help them successfully reach their goals.

**Specialty Mental Health Services (SMHS):** Services provided to children and adolescents up to age 21 who are Medi-Cal beneficiaries and meet medical necessity criteria. Service components include, but are not limited to: outpatient mental health services, medication support, targeted case management, therapeutic behavioral services (TBS), crisis intervention, Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC).

**Mental Health Plan (MHP):** Provides or arranges for the provision of specialty mental health services to Medi-Cal beneficiaries in the county that meet medical necessity criteria, consistent with the beneficiaries' mental health treatment needs and goals.

**Linked child/youth**: Children or youth that have been assigned by the Sacramento County Access Team to receive specialty mental health services.

**Unlinked child/youth:** Children or youth not yet assigned by the Sacramento County Access Team to receive specialty mental health services and will be encouraged to participate in such services, if eligible.

**Child and Adolescent Needs and Strengths (CANS) 50:** A multi-purpose mental health tool used as a communimetric tool to support care planning, decision making and outcomes management. The Primary Mental Health Provider is required to complete a CANS 50 assessment within 60 days of beginning services, but prior to the treatment plan completion date, every 6 months from the admit date or more often if clinically indicated, and at discharge.

**Primary Mental Health Provider (PMHP)**: A county operated clinic or a contracted provider with Sacramento County Division of Behavioral Health Services that delivers outpatient specialty mental health services to children, youth, and families. The PMHP is responsible for delivering the majority of mental health services to the client, and will coordinate with adjunctive services such as psychological testing, TBS, and TFC, when indicated.

**Intensive Care Coordination (ICC):** An intensive form of targeted case management that facilitates the assessment of, care planning for, and coordination of services for children and youth. ICC includes urgent services for beneficiaries with intensive needs. ICC is intended for children and youth who are involved in multiple child-serving systems, have more intensive needs, and/or whose treatment requires cross-agency collaboration.

**ICC Coordinator**: The ICC coordinator is responsible for facilitating meetings and coordinating complex care systems in a manner that is integrated and addresses the identified goals, objectives and activities of all parties involved with the service to the child/youth and family. The ICC Coordinator is the lead of the ICC-CFT and facilitates CFT meetings.

**Intensive Care Coordination-Child and Family Team (ICC-CFT):** The ICC-CFT is a formal CFT for those children/youth who are receiving specialty mental health services. It includes, at a minimum, the child/youth and his/her family, CPS social worker (when applicable), Probation officer (when applicable), any caregivers or group home staff, ICC coordinator, Child and Family Advocates and any individuals important in the child/youth's life and who are identified by the child/youth and family and invited to participate. If the PMHP does not have Advocates in their program, they will request Advocate support from the County Advocate program. The ICC-CFT meetings must occur within 60 days of determining eligibility and on a regular basis, no less than every 90 days.

**Intensive Home Based Services (IHBS):** Individualized, strength-based interventions designed to improve mental health conditions that interfere with the child's or youth's functioning. Interventions are aimed at helping the child/youth build skills for successful functioning and improving the family's ability to help the child/youth successfully function in the home and in the community. The services are not office based and are provided in the home and/or community.

**Therapeutic Foster Care (TFC):** A short-term, intensive, highly coordinated, trauma-informed, and individualized intervention, provided by a TFC parent to a child or youth who has complex emotional and behavioral needs. TFC is

intended for children and youth who require intensive and frequent mental health support in a family environment.

**Purpose:**

The purpose of this document is to describe Sacramento County's Division of Behavioral Health Services policies and practices related to ICC-CFTs in the context of mental health treatment.

**Details:**

It is the policy of the Division of Behavioral Health Services to establish expectations regarding the implementation of ICC-CFTs under the County MHP. An ICC-CFT must be in place for children and youth receiving certain Specialty Mental Health Services (e.g., ICC, IHBS, TFC) and children and youth residing in a group or Short-Term Residential Therapeutic Program (STRTP) placement with an existing case plan.

1. The ICC-CFT process follows the principles, values, and practices of the ICPM, and reflect the culture, developmental levels and preferences of the child, youth, and family.

2. The ICC-CFT process adheres to all components indicated in the most recently published Medi-Cal Manual, Medi-Cal standards, and County's documentation and billing standards.

3. The PMHP shall convene and facilitate ICC-CFT meetings to create an effective working alliance for change in which the ICC-CFT is conducted as a collective process.

4. The ICC-CFT process should reflect and document that families have capacity to address their problems and achieve success if given equitable opportunity and supports. Engagement with families is fundamental to the ICC-CFT process for a shared decision-making process.

5. The ICC-CFT process builds on unique values and capacities by eliciting the participation of everyone on the team. Care must be taken to integrate cultural needs and norms into the plan. Team members help children, youth, and families recognize their strengths, and encourage and support them to develop solutions that match their strengths and preferences. The team must support the power of learning from mistakes when strategies do not work as intended so that the plan can be revised to improve outcomes.

6. It is the responsibility of all ICC-CFT members to monitor and coordinate the ICC-CFT process to verify that team decisions and case planning adhere to this policy and safety recommendations determined by the ICC-CFT.

7. The PMHP shall ensure the ICC-CFT is a safe environment that fosters vulnerability, empowerment and empathy across all members of the ICC-CFT, which includes the youth, family, natural supports, clinician, advocates, child welfare (when applicable), probation (when applicable), Child and Family Advocates, education, and other system partners. If needed, ICC-CFT meetings must include an interpreter, at no cost to the family, to ensure effective communication and clear understanding when family members are limited English proficient (see Policies and Procedures CCES 01-02 and QM 01-03).

8. Upon admission into a PMHP program, every family shall be screened using the ICC-IHBS screening form in Avatar or the PMHP's EHR to determine the need for an ICC-CFT.

9. Confidentiality:

    a. When the ICC-CFT convenes, members will discuss and address any concerns related to sharing information openly and transparently. Sharing relevant information allows families and professionals to build trust in each other and in themselves. All ICC-CFT members must abide by State and Federal confidentiality requirements (i.e., WIC, Section 832).

    b. The ICC-CFT shall sign, review and revisit releases of information (ROI) so that all ICC-CFT members and participants understand the relevant information to be shared within the ICC-CFT.

10. CANS 50:

    a. There must be only one CANS for each child/youth's ICC-CFT; if a CANS has been completed by a county placing agency or by county MHP, the existing CANS will be shared as early as possible with all members of the ICC-CFT, then update as needed. A CANS completed by a mental health provider must be shared with the Child Welfare Social Worker, as early as possible.

    b. The PMHP shall obtain ROIs to share pertinent information, except information related to drug and alcohol/substance use issues, upon which this information shall be redacted unless the signed ROI

indicates drug and alcohol/substance use information may be disclosed. At any point, the client can change their decision to release any pertinent information.

c. Within the ICC-CFT process, the CANS may support engagement with youth and families in their own care by assessing the well-being and identifying a range of social and behavioral needs of the youth and caregivers. Used within the ICC-CFT, the CANS shall be used as a communimetric tool to support care planning and coordination, collaborative decision-making and monitoring progress and outcomes for the family.

11. Training:

a. The PMHP shall ensure their staff receive: foundational ICC-CFT training, skills and teaming practice, facilitation and advanced facilitation skills (if applicable to the staff's role).

b. In addition to training staff on the philosophy of ICC-CFTs, the PMHP will either provide or give access to coaching and guidance to all ICC-CFT Facilitators to maintain a neutral position, mediate differences of opinion, provide conflict resolution, ensure topics discussed are agenda driven, help members manage biases, elicit the child/youth and family perspectives during all phases of the ICC-CFT process to overcome barrier(s) (e.g., fear of retaliation, fear of repercussion, power distance) for an honest and open conversation among the stakeholders and to manage time.

**Procedure:**

1. Convening an ICC-CFT:

a. The MHP is responsible for convening the ICC-CFT for children and youth who are receiving ICC, IHBS, or TFC.

b. Any member of the treatment team (including child/youth and family) can request an ICC-CFT. The ICC-CFT will be held at places and times where the child/youth and family is most comfortable.

c. The PMHP will utilize the ICC screener with all families to determine the need for an ICC-CFT upon admission, and for best practice, when completing a Client Plan update. If an ICC-CFT is deemed appropriate, the family will be assigned to an ICC-Coordinator, who will convene the ICC-CFT and determine the need for ongoing meetings.

d. In preparation for ICC-CFTs, the PMHP will provide education to the child, youth and family related, which includes but not limited to the purpose, who can participate in an ICC-CFT meeting, structure of the meeting, and common topics discussed during an ICC-CFT meeting.

e. If the child, youth, and family already have an established ICC-CFT through CPS or through another provider, the contracted facilitator shall ensure a transition for the ICC-CFT, including but not limited to expanding and evolving the existing team process so that any additional team members, including county staff, can be included when appropriate.

f. An ICC-CFT should occur as soon as possible and adhere to WIC, Section 16501. The initial ICC-CFT meeting should not be delayed to accommodate a pending mental health screening, assessment, or pending referral for services.

g. When applicable, the ICC-CFT can provide input to the placing agency (e.g., CPS or Probation) that identifies the most appropriate placement for the child or youth, while always considering the least restrictive placement option.

h. For children receiving SMHS that require an ICC-CFT (ICC, IHBS, and services provided through the TFC services model), the ICC-CFT should reassess the needs of the child or youth, and adapt the plan in a timely manner, but not less than every 90 days. Urgent issues, such as safety concerns, risk of placement disruption, and/or ineffective support services, should be addressed immediately.

i. After a crisis, an emergency ICC-CFT meeting will be convened with the child/youth, all appropriate team members, and any additional team members, including county staff when appropriate, to create, review and/or revise safety plans and treatment plans, as soon as possible.

2. ICC-CFT/Teaming Process:

a. Team composition shall be guided by the child/youth/family's input and their needs and preferences.

b. The ICC coordinator will ensure an ICC-CFT is comprised of the child or youth, family and all of the ancillary individuals as determined by the family. A representative of the child or youth's tribe or Indian custodian, foster family agency social worker, or STRTP shall be

included when applicable. The ICC-CFT members share responsibility to evaluate, plan, intervene, monitor and refine services over time.

c. The PMHP will be responsible for coordinating with the ICC-CFT to identify needed contacts, build consensus within the team around collaborative plans, actively support the agenda, and ensure that the family voice and choice is heard throughout the teaming process. Team members' roles will be identified and will be clarified throughout the term of the ICC-CFT.

d. The PMHP will be responsible for coordinating with the ICC-CFT to identify a Facilitator. The decision of who facilitates the ICC-CFT meeting should be a shared decision that includes the preferences of the child/youth and family members. Other team members may take on the role of the Facilitator.

3. ICC-CFT Meetings:

a. ICC-CFT meetings should have a clear purpose and follow a structured format (e.g. CFT Meeting Action Plan).

b. An agenda will be generated by the Facilitator, with input from the team, for each ICC-CFT meeting. The agenda should include all pertinent topics such as: successful treatment of the child or youth's mental health needs, permanency and placement, classroom and community-based support, medical needs, and achieving goals in other child-serving systems in which the child or youth is involved.

c. The agenda and/or previous meeting minutes will be distributed by the Facilitator one week before the scheduled meeting. This will provide adequate time for the team to review the agenda and address the minutes before the following meeting.

d. Plans must be individualized, culturally responsive and trauma-informed. The team should routinely measure and evaluate the team's progress and emerging needs. Team members shall be responsive when plans may require revision.

e. If a team member is unable to attend the ICC-CFT meeting in person (due to proximity issues or other conflicts), participation is encouraged by HIPAA compliant video conferencing or phone. This option may be helpful when a child is placed in another county or when schedules do not allow in-person participation. Before the ICC-

CFT meeting ends, team members should identify how to provide updates to absent team members in a timely manner.

f. When age-appropriate, a child or youth should always participate in an ICC-CFT meeting. Participation should be limited if the nature of the meeting's agenda is not suitable for the child or youth. Some examples may include: the focus of the meeting is only about the parent or parents' needs as it relates to the child or youth, or the main topic of discussion is of a sensitive adult nature.

g. It is the responsibility of the placing agency to determine the most appropriate placement in order to achieve public safety, child safety, permanency and well-being.

**References:**

ACL 16-84 – Requirements and Guidelines for Creating and Providing a Child and Family Team

ACL 18-09 – Requirements for Implementing the Child and Adolescent Needs and Strengths Assessment Tool Within a Child and Family Team

ACIN I-21-18 – The California Children, Youth, and Families Integrated Core Practice Model and the California Integrated Training Guide

ACL 18-23 – The Child and Family Team (CFT) Process Frequently Asked Questions

ACL 18-85 – Clarification Regarding Sharing of CANS Assessments by County Placing Agencies and Mental Health Programs

ACIN I-71-18 – Using Team Meetings to Increase Cross-system Collaboration Between Local Child Welfare and Education Agencies (LEAs)

**Related Policies:**

CCES 01-02 – Procedure for Access to Interpreter

QM 01-03 – Interpretation Services by Family Members

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**Contact Information:**

BHS-DHS@saccounty.net